



Endocrine & Diabetes Center

QUESTIONNAIRE FOR INITIAL EVALUATION OF WEIGHT MANAGEMENT

Name of your referring physician: _____

Name of your primary care physician: _____

Are you self-referred? Yes No (If yes, how did you find us?) _____

Name	Date of Birth	Age	Gender
Marital Status	Number of children	Occupation	Ethnicity

WHAT IS YOUR WEIGHT RELATED CONCERN? _____

WHEN DID YOU FIRST DEVELOP A WEIGHT- RELATED CONCERN? _____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Type 1 diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type 2 diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No. If yes please answer the following:

- I have angina.
- I have history of coronary artery disease
- I have had a myocardial infarction (heart attack)
- I have had coronary bypass surgery; Date _____
- I have had coronary angioplasty/ stent placement, Date: _____
- Date of your last EKG _____
- Date of your last cardiac evaluation _____
- Name of your cardiologist _____

Elevated cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
High Blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Underactive thyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Sleep apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Fatty liver	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Psychiatric disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Arthritis/ Joint pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____
Polycystic ovaries	<input type="checkbox"/> Yes	<input type="checkbox"/> No, if yes describe _____

Other: Please describe: _____

PREVIOUS NUTRITIONAL INSTRUCTION Yes No If yes,
When? _____ Where? _____
Are there foods that you can't or don't want to eat? Yes No
If yes please describe _____
Do you eat in response to emotional distress? Yes No
Do you eat between meals (snacking)? Yes No

WEIGHT HISTORY OVER THE PAST 6 MONTHS:
 Stable Lost weight _____ Lbs. Gained Weight _____ Lbs.
Do you have a weight goal in mind? Please describe _____

EXERCISE HISTORY:
Do you exercise? Yes No; If yes what kind? _____
Carido Yes No; if yes describe _____
Strength training Yes No; if yes, describe _____
Walking Yes No; if yes, describe _____

YOUR PREVIOUS ATTEMPTS AT WEIGHT REDUCTION:
How many serious weight reduction attempts have you had? _____
As there a program that appeared to work for you? _____

HAVE YOU HAD ANY BEHAVIOR MODIFICATION EDUCATION? Yes No, if yes
please describe _____ For how long? _____ months

HAVE YOU EVER BEEN ON WEIGHT LOSS MEDICATION OR ANTI-OBESITY DRUGS?
 Yes No; If yes which one? _____
Did you have side effects? _____

NOTE: Several anti-obesity drugs should not be used when there is a concern regarding certain conditions. Please answer the following:

Have you had a personal history of pancreatitis? Yes No, if yes please describe

Do you have personal or family history of medullary cancer of thyroid or multiple endocrine neoplasia? Yes No, if yes describe _____

TIME & FINANCIAL ISSUES: Do you have problem with time or financial resources to effectively follow and manage your weight management program. Please describe _____

FOR WOMEN:

- Are you currently preparing for pregnancy? Yes No; if yes describe _____
- If you are sexually active and you are in child bearing age, what method of birth control do you use?

SLEEP & WORK:

- On average how many hours of sleep do you get at night: _____ hours
- Do you have interrupted sleep? Yes No; if yes describe _____
- Do you have sleep apnea? Yes No; if yes describe _____
- Do you use CPAP, BiPAP Yes No; if yes describe _____
- How many hours a day do you work? _____ hours. Type of work? _____

PAST MEDICAL HISTORY:

Past medical illnesses: Please explain:

Past surgical procedures: Please explain:

FAMILY HISTORY:

- Father: _____
- Mother: _____
- Sister: _____
- Brother: _____
- Others: _____

SOCIAL HISTORY:

- Alcohol Yes No; If yes describe _____
- Smoking history Yes No. Years of smoking _____ Amount _____
- Recreational drugs Yes No; If yes describe _____
- Hobbies: _____

- ALLERGIES:** I have no known drug allergy.
- I am allergic to following drugs: _____

PLEASE BRING THE FOLLOWING REPORTS WITH YOU:

- 1- **MEDICATIONS:** Complete the medication sheet. Include, name, dose and frequency of drugs you are using.
- 2- **MOST RECENT LABORATORY TESTS:** Attach a copy of the results
- 3- **MOST RECENT RADIOLOGICAL STUDIES:** Attach a copy of the results
- 4- **OTHER HEALTH CARE PROVIDERS:** Please attach name and contact information for all health care providers you see regularly.